An Ethnographic Analysis of the Restrictions of Effective Mental Health Treatments in Moroccan Society: Where Do We Go From Here?

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With its simultaneously omnipresent traditional and modern culture, Morocco possesses a unique binary demeanor. This is especially true when discussing the attitudes toward and perceptions of mental illnesses and those who suffer from them. It is important to understand the various components that influence perceptions, help-seeking behaviors, and overall attitudes toward perceived mental illness within Moroccan culture (Al-Krenawi, et al., 2009). Because there are a variety of ways in which patients conceptualize and articulate mental illnesses across cultures, it is necessary to consider factors such as cultural beliefs, societal legislative influences, local treatment availabilities, family involvement, awareness, stigmatization, and historical context to fully understand the challenges that arise concerning this complex issue. This is principally so in countries such as Morocco, where the conflicting ideals of traditional and Westernized psychiatric treatments often collide. The implementation of modern, westernized mental health treatments into a population that is already deeply embedded in traditional and religious healing methods has created an internal conflict surrounding the search for balance between the two practices (Stein, 2000). This can be problematic when attempting to treat cases, as practitioners' misconceptions can lead to access barriers, misdiagnosis, or inappropriate treatment (Al-Krenawi, et al., 2009).

History of Traditional and Westernized Psychiatric Treatment in Morocco: A Timeline

Ancient Berbers

Often overseen and overshadowed by the vast influence of Islam, the indigenous Berber population has played an important role in shaping the perception of mental illness in Morocco (Fassaert, 2009). According to the indigenous Amazigh peoples' (although most commonly referred to as Berbers), mental illness has been defined as a product of evil sorcery, known as

sHour, since 3rd century BC. It is believed that when ingested, touched, or in close vicinity with this *sHour*, chronic psychological disturbances occur. This *sHour* is said to take on numerous different forms, such as a seemingly innocent but cursed inanimate object that occurs in nature or is even intentionally plotted objects by an evil sorcerer seeking revenge. To dispel this *sHour*, local *seHaras* or *fquihs*, experts in sorcery and magical arts, are asked to treat victims with a healing antidote or provide them with an evil object of their own to protect them from the evil that they have unwillingly encountered (Stein, 2000).

Islam's Influence

A major sculpting figure in psychiatric treatments was the introduction of the Islamic faith in 680 AD, in which the Qur'an describes the presence of an evil infective creature—a *djinn* that inhabits a person's body—that plagues them with a mental illness. Prior research indicates that the psychiatrists often interpreted the description of this *djinn*'s possession as the beginning of schizophrenic ideations in clinical terms (Stein, 2000). Traditional methods, such as the use of rituals at historical holy men's shrines (*marabouts*), animal sacrifice, residency near shrines, or the visiting of a religious scholar and sorcerer (*fquih*), are examples of options that are sought out in attempt to gain relief from mental illness. The goal is that the *djinns* will voluntarily expel from their mortal inhabitants in exchange for these remunerations. However, if these creatures exhibit resistance, they are to be exorcised by the *marabouts*. *Marabout* practices range from the implementation of herbal fumigation or assignment of amulets, to reading Koranic passages and magical enchantments, to even the beating of the "infected" to dispel the *djinn* (Stein, 2000). These were the hegemonic practices and ideals for a number of centuries, notably until the 20th century French invasion of Morocco.

French Colonization

The French colonization of 1912 marked the first, and lasting, integration and acculturation of Westernized psychiatric services into the Moroccan culture. Moroccans eventually took over these French institutions and began practicing more modern forms of healing methods, including medicinal diagnoses, the utilization of pharmacology, and psychodynamic treatment, rather than religiously-based healing (Stein, 2000).

The Amalgamation of Traditional and Westernized Healing Practices circa 2000s

A variety of terms have been used to describe these illnesses, ranging from handicapping to sorcery in recent years, due to Morocco's diverse and historical context in regard to the mentally ill (Kadri, 2004). In such cases where sorcery and religion are seen to play predominant roles in psychiatric deviances, spiritual care will be more likely, whereas cases in which more modern clinical perceptions are prominent will lead to patients receiving mental and medical care (Fassaert, 2009). One can see why the perceptions of evil spirits inhabiting the bodies of those with mental illness can be problematic when attempting to treat patients. Attesting psychological disorders to external, supernatural factors can often create a generalized fear of the implications of these disorders, impacting diagnosis on a basis of clinical terms (i.e. inaccuracy due to stigma-induced withholding of patient information, insufficient treatment due to lack of patient compliance, etc) (Stein, 2000). Additionally, social development issues such as access to basic education and quality primary health care, elimination of illiteracy, reduction of poverty and social inequality, and increasing training and employment are all current challenges affecting the mental illness sector of cultural medical systems in Morocco (WHO-AIMS Report, 2006).

These factors, along with the historical smelting of Berber, Islamic, and French ideals and practices, suggest that it is "not uncommon for individuals with traditional backgrounds to have health beliefs that deviate from our Western biomedical models, characterized by a more external

locus of control, and fatalistic beliefs" (Faessart, 2009, p. 214). That is, many attribute mental illness to factors outside of the human body rather than intrinsic causes. Although Morocco has a deep-rooted involvement in Western medicine due to the French, traditional healers are still thought of as able to remove evil sorcery and expel the evil spirits causing the patient mental torment (Faessart, 2009). Due to variances of acculturation, as well as area of origin from Morocco, specific types of healers, practices and overall beliefs remain on a spectrum throughout the country rather than on a basis of choosing "one or the other" (Al-Krenawi, 2001).

Governmental Influences

Legislative Provisions

There is a significant lack of up to date legislative provisions implemented by the Moroccan government. The last piece of mental health legislation was enacted in 1959; the last mental health policy was revised in 2002; and the last revision of the mental health plan was in 2004 (WHO-AIMS Report, 2006). Additionally, other helpful resources for the mentally ill are complicated to attain. For example, although a welfare card system was enacted as a part of the latest revision of Morocco's mental health policy in 2002, the process to receive a welfare card is far from simple. Medical practitioners must assign a percent disability to each prospective cardholder, which is then reviewed by a national committee that approves or denies benefits to these individuals based on analysis of the disability, including mental illness. This system is in place to reduce or waive the cost of some public and departmental services for the mentally disabled. Additional provisions protecting individuals from discrimination (lower wages, unjust termination from job position) were implemented with this revision; however, also according to the WHO-AIMS report, there are no such protections in place "concerning, employment,

housing, or financial support for persons suffering from mental disorders" (WHO-AIMS Report, 2006, p. 21).

Although there are a few legislative provisions in place concerning the wellbeing of mentally ill citizens, there are none that obligate employers to hire a certain percentage of employees with these disabilities, prioritize subsidized housing for people with severe mental disorders, nor protection from discrimination influencing the equal distribution of housing for people with severe psychological illnesses (WHO-AIMS Report, 2006).

Financial Provisions

Statistics presented in the latest WHO-AIMS Report on Mental Health Systems in Morocco accounts for the government's investment toward mental health resources as being merely 4% of the entire health department's funding, with roughly half of this 4% allocated to mental hospitals. As far as treatment coverage and cost, it is worth noting that only severe mental disorders are covered within social insurance schemes (WHO-AIMS Report, 2006).

An overwhelming majority of the population is left unable to afford medicinal treatment. Individuals considered to have the most "severe" mental disorders, making up only 30% of the population, are the only citizens with access to free psychotropic medicines. Based on the WHO-AIMS Report in 2006, "the out of pocket cost of antipsychotic medications is 1.35 dollars per day, and the cost of antidepressant medication is 1.80 dollars per day, both costing roughly 2% of the daily minimum wage" (WHO-AIMS Report, 2006).

Based on this available evidence, supplemented by the fact that the most recent formal, extensive study and publication concerning Morocco's medical systems was conducted over a decade ago, it is apparent that legislative and financial provisions for the mentally ill in Morocco are outdated, scarce, vaguely defined, and insufficiently funded. Updated data collection is

necessary to analyze the results of these provisions and account for the efficacy of governmental efforts toward more affordable and attainable services and resources (WHO-AIMS Report, 2006).

Current Treatment Statistics

Regional Differences: Urban vs. Rural Availabilities

Recent studies suggest that numerous sociodemographic and socioeconomic variables influence psychiatric treatment methods. Ethnic populations are far more likely to resort to traditional healing methods (family, friends, and religion) than those with greater accessibility to mental health services, higher education, or modern family values and beliefs regarding psychiatry (Al-Krenawi, et al., 2009). Morocco's collectivist ideology makes for "a far slower pace of social change and higher rate of social stability" than that of the rapidly changing and individualistic Western culture. Both Moroccan traditional healers and modern medical practitioners have been sought out as mental health treatment—demonstrating the multifaceted amalgamation of Moroccan psychiatry as it exists today amidst traditional and Western practices (Al-Krenawi, et al., 2001).

Moreover, the unequal distribution and availability of resources for the mentally ill varies widely depending on the types of regions in which individuals reside. There is a heavy concentration of mental illness practitioners in large, urban cities such as Casablanca (Stein, 2000), where the density of mental health practitioners per capita is 1.37 times greater in these urban areas than the density for the whole country (WHO-AIMS Report, 2006). According to the latest WHO-AIMS Report on Mental Health Systems in Morocco conducted in 2006, the proportion of psychiatry beds located in or near the largest city in Morocco is 9.23 times greater

than that of the whole country, mirroring the overall rate of urbanization, which has risen to 55.1% (WHO-AIMS Report, 2006).

The location and type of mental health facility is significant as far as staff abundance and treatment quality. Research shows that, only a decade ago, 57% of Morocco's psychiatrists worked only in or for non-government organizations, for-profit mental health facilities, or private practices; meanwhile, more than 38% of Morocco's psychiatrists worked only for government administered mental health, and only 5% of Morocco's psychiatrists worked for both (WHO-AIMS Report, 2006). These residences and practitioners are located primarily in urban areas and far less so, if at all, in rural areas. The numbers are even more staggering when looking at psychosocial workers: 92% of psychologists, social workers, nurses and occupational therapists work only in government administered mental health facilities (WHO-AIMS Report, 2006). Based on this data, it is apparent that psychiatrists and human resources are far scarcer in rural areas, leaving minimal access for the other half of rural-residing Moroccans. Instead, these residents may only have access to less structured forms of healing such as visiting community *marabouts* that are scattered generously throughout the less urbanized areas (Stein, 2000). Additionally, language barriers with the traditional practicing Berbers and limited access to mental health services for those in rural communities creates inequality of lack of service options between these peoples and those in larger, more urbanized cities (WHO-AIMS Report, 2006). Therefore, the perceptions of psychiatry and psychiatric patients in urban and rural areas may differ substantially based on their exposure, or lack thereof, to these resources (Stein, 2000).

Staff to Patient Ratio: Distribution of Mental Health Practitioners

In 2006, results reported from an extensive study conducted by the World Health Organization Assessment Instrument for Mental Health Systems exhibited confounding

information regarding the deficient aggregate amount of mental health practitioners in Morocco. First, these results indicated that only 20% of primary practitioners had any interaction with a mental health professional on a monthly basis. Meanwhile, only 4% percent of all medical training was dedicated specifically to mental health knowledge and practices, with the total number of human resource workers in mental health facilities or private practices being 1,464 (a ratio of 4.9 per 100,000 population.) In comparison to the number of mental health cases in Morocco, there is an acutely inadequate amount of mental health facilities and trained psychiatric staff. In a country sustaining a population of 30 million people, there are a total of 306 practicing psychiatrists—a ratio of roughly 1.02 per 100,000 populations. There are only 74 outpatient mental health facilities in Morocco, of which 4 facilities are for children and adolescents only, and 9 mental hospitals in total, none of which are specified for children and adolescents. Furthermore, only 1% of primary and secondary schools have either a part-time or full-time mental health professional for children and adolescents on site. Neither official day treatments nor community residential treatments currently exist and merely 15 community-based psychiatric units are currently available. This number is even smaller for those suffering from substance abuse, including alcohol, with only 2 residential sites that often serve solely as detoxification facilities. At the time that this data was collected a decade ago, the number of beds had decreased by 11% within the last five years and, overall, these facilities housed 9523 users (31.86 per 100,000.) The outcome of this study also revealed that none of the current outpatient facilities provide follow-up care in the community or mobile mental health teams, nor are there accessible post-treatment employment programs outside the mental health facility, making integration back into society difficult for the mentally ill (WHO-AIMS Report, 2006).

These deficiencies are primarily due to lack of funding and recognition by the government, as mental illness is not considered a priority on a political level. Due to the complex blending of traditional and modern viewpoints, medical practitioners often provide inadequate treatment that do not meet patient expectations. If the patient holds deep-rooted cultural and religious beliefs, practitioners must act accordingly and be cautious of unknowingly disregarding these beliefs in order to effectively reach these individuals with modern medical systems. Failure to decode, analyze, and take into account these traditional ideologies leads to misunderstandings, unclear communication, ineffectual diagnosis, patient resistance, disappointment with received services, and even premature termination of treatments (Al-Krenawi, et al., 2001).

Family Involvement

Shortage of treatment facilities, training, employment and support in Morocco causes patients to be treated predominantly at home by family members, specifically by their mothers. Arab societies are described as high context, in which they “emphasize the collective over the individual; making social relations patriarchal and spontaneous. The family is important to the homologous interrelationship between the individual and the group, and may profoundly determine individual's social and economic status” (Al-Krenawi, et al., 2009, p. 28). It would make sense, then, that this collectivist culture places a large emphasis on nuclear and extended family members as the primary foundation and source of responsibility and input for patients suffering with mental illnesses. Family contribution is expected far more by Moroccan families than it is Western families as far as managing the development, behavior, and patterns associated with their loved one's mental disorder (Okasha, 2003). There is a clear distinction from typical Western strategies, as family members are consulted before mental health professionals. With such a kin-focused view on caretaking, it is rather ironic that less than 20% of family

associations had contact with the mental health facilities over a period of one year if these family members are, in fact, placed in treatment centers (WHO-AIMS Report, 2006).

Awareness

In 2003, general consensus in Morocco suggested that widespread awareness of psychological and social factors in children and adolescents was greatly insufficient among the majority of parents and teachers (Okasha, 2003). In attempt to tackle this issue, professional, government and international agencies implemented 21 public education and awareness campaigns on mental health and mental disorders countrywide, targeting the general population, children, adolescents, women, trauma survivors, vulnerable or minority groups, health care providers, teachers, social services staff, leaders and politicians, and other groups linked to the health sector, from 2001 to 2006. There has been no such update on the results of these campaigns, but further fieldwork is needed in order to examine the efficacy of these efforts.

However, very few research articles, only 0.01 of all publications over this five-year span, encompassed the topic of mental health. Furthermore, less than 20% of primary and secondary schools encourage or promote mental health awareness and prevention, although there is a clear deficit in sectors of research and awareness efforts throughout vast areas within Moroccan culture. Another contributing factor is the literacy rate in Morocco: merely 63.3% for men and 38.3% for women. Illiteracy creates a barrier of communication, leading to lack of understanding, and consequently a struggle to develop a ubiquitous sense of acceptance and progression within the general public. This lack of education throughout society hinders the recognition of individuals with psychological disorders in a non-stigmatic manner (WHO-AIMS Report, 2006).

Stigma as a Barrier

Mental Illness Viewed Through a Religious Lens

Predominantly Muslim countries have a profound effect on how competency and insanity are defined and approached (Okasha, 2003). For example, in communities where Islam is prominent, such as in Morocco, mental illness stems from the idea that "it is the consequence of failure as a Muslim to live by Islamic rules" (Fassaert, 2009, p. 214). It is crucial to note not only the prevalence of specific diagnoses, but also what Moroccans view as and constitute to be a mental illness. Stigma is often judged based on the nature of mental illness (i.e. deviant behavior, minor depression, severe schizophrenia, etc.) (Al-Krenawi, et al., 2009). Family elders may bring individuals who elicit behavior that deviates from the societal norms, such as drinking alcohol, premarital sex, or the nonobservance of public rules for the fasting month, to psychiatrists to evaluate their mental state (Okasha, 2003). When these socially deviant behaviors are psychologized, it serves four purposes: (1) to appear as though the individual is actively abiding by Islamic code, (2) to avoid legal punishment assigned to Islamic code breakers, (3) to save their family shame, and (4) to maintain social status as a non-code breaking, and therefore an accepted and desirable candidate for marriage under the Islam faith (Okasha, 2003). Additional traditional etiologies can be attested to magic, demons, sorcery, the "Evil Eye" (a prominent figure in Muslim ideology), physical manifestations, family adversity, divorce, economic troubles, unemployment, environmental factors, car accidents, and traumatic events (Al-Krenawi, et al., 2001). The lines of diagnoses become blurred based on these various terminologies considered to be sufficient etiologies of mental illness.

Gender Context

Another stigmatizing influence in treatment of this illness is due to the gender context: the high frequency of male hospitalizations versus female ones, in which cultural taboo has deemed

this even more unfavorable for women (Kadri, 2004). Due to the damaging effects projected to marital prospects, prior research indicates women, especially those who are unmarried, rarely utilize mental health services, or even domestic abuse services, due to embedded ideals of embarrassment and shame. Women are deemed of lesser value in this regard than are men who seek treatments, as women represent the family's honor and attempt to avoid shame (Kadri, 2004).

Somatization and Self-Help

Self reports, patients' accounts, and clinical descriptions of mental disorders and their symptoms should be especially considered, as an overwhelming majority, roughly 70-80% of psychiatric patients in Arab countries, over-somatize their thoughts and emotions (Okasha, 2003). Somatization is the assignment of these thoughts and emotions as physical ailments. To counteract and protect oneself from this social and cultural ignominy, somatization is a defense mechanism that serves the purpose of privacy while also seeking treatment methods that are deemed safe, socially and morally acceptable, and justifiable in Arab-Muslim cultures (Al-Krenawi, et al., 2001). Since it subdues the presence of psychological deviations, somatization is addressed most often, first, with a traditional healer, general practitioner, or internist rather than consulting a psychiatrist. If this factor isn't accounted for, medical professionals can often overlook the possibility of somatization, treating the patients for the physical symptoms rather than further analyzing or referring them for psychological treatments (Okasha, 2003).

Although somatization is problematic and prevalent, even more critical circumstances may occur; in many cases, the stigma of mental illness may prevent the presentation of mental symptoms to a regular physician at all. Moroccan patients' reluctance to report mental health problems, along with misunderstandings impacting physician-patient communication, can

impede the execution of proper psychological treatment (Fassaert, 2009). There is also an emphasis on the belief of self-reliance and determination to overcome mental illness on one's own (Fassaert, 2009). Difficulties in overcoming stigma attached to mental disorders in non-Western cultures are said to be influenced by "moral issues in defining one's problems, the belief that traditional practices are effective, and the perception of incompetence attached to individuals who request outside assistance" (Al-Krenawi, et al., 2001, p. 46).

Attributing symptoms to external components accompanies a sense of helplessness, in which the person is assumed to have no control (Al-Krenawi, et al., 2001). This learned helplessness plays a large part in maintaining the harmful complacency of Moroccans on the general premise of psychological disorders (Murphy, 1976). Teaching patients that they can, in fact, attain a sense of control over these internal experiences through treatment and that their conditions do not have to be detrimental and incurable is pivotal (Al-Krenawi, et al., 2001).

The Concept of Shame and Societal Pressures

Due to the historical, familial, legislative, financial and social facets surrounding mental disorders, there has been a strong sense of taboo and stigma that has developed within Moroccan culture. Repercussions of this stigma include, but are not restricted to, fear of emotions, fear of treatment, or reluctance to self-disclose due to marital, familial, societal and cultural perceptions (Al-Krenawi, et al., 2009). Families caring for members suffering with mental illnesses report maltreatment, mockery, distrust, neglect, and fear as daily adversities by their peers and the overall community (Kadri, 2004). It is apparent, based on these accounts, that stigmatizations are prevalent, causing families to experience communal shame. It is also reported that mothers, specifically of children with mental illness, suffer greatly from crippling guilt, misery, and isolation (Al-Krenawi, et al., 2009). Help-seeking processes are also mediated by an individual's

level of acculturation. In 2004, Dr. Nasser Aloud conducted the largest study on attitudes toward Arab-Muslim mental health seeking. The results of this dissertation indicated that ‘‘favorable or unfavorable attitudes toward seeking formal mental health services is most likely to be affected by cultural and traditional beliefs about mental health policy” (Al-Krenawi, et al., 2009, p. 27). On the premise of this hegemonic ideology, it is not surprising that there is a severely negative connotation that has been consistently associated with the mentally ill in Moroccan culture.

The heavily weighted concept of honor and shame greatly shapes the Arab lifestyle and culture, as any admittance of mental illness is believed to have an impact on the collective’s status and sense of respect. Unfortunately, negative perceptions are so prevalent that that Arab-Muslim individuals still attach stigma labeling to those who seek formal mental health services regardless of the region in which they live or personal level of education obtained. Prior research attributes this to “the primary component of the complexity of this issue of stigmatization, in relation to utilizing service, as directly being linked to the cultural and social aspects of a particular society” (Al-Krenawi, et al., 2009, p. 32). The Moroccan population’s negative perceptions of mentally disabled individuals are a rigid deterrent in the progression of mental illness advancements.

Discussion and Moving Forward

Modernized Studies Required

It is worth noting that the statistics provided within this thesis were compiled from the last official report concerning Morocco’s medical and mental health systems, which was studied and published over 10 years ago. Furthermore, existing research regarding mental illness in Morocco are based upon cross-cultural analyses of Arab-Muslim countries rather than within the country alone. There is only one report, published in 2006, specifically focusing on the components of

Morocco's medical and mental health systems. Other related studies are primarily grounded in the accounts of the patients suffering from mental illness, medical professionals and mental practitioners, as well as patients' families. There is a blatant need for updated scholarship concerning the accounts of the general public in order to decipher what the greatest limiting factors are in Moroccan society today. Somatization should be taken into consideration in the design of mental health policies and programs, as well as addressing the need for focused treatment options for mentally ill children as well as those battling substance abuse (Okasha, 2003).

In 2004, The World Bank report on social protection in Morocco suggested expenditures being used to expand treatment services to rural areas and financing hospital reform (WHO-AIMS Report, 2006). It would be worthwhile to follow up on whether or not these expenditures were implemented and the current state, if any, of these services. Also, at the time that this report was published, Morocco was said to be undergoing decentralization, integration of mental health into primary health care, reduction of the number of beds in mental hospitals, and an increase in the services available to patients at the community level, as well as holding a national conference on advocacy and stigma reduction (WHO-AIMS Report, 2006). Follow-up research is necessary to track the long-term effectiveness of these applications.

Rather than just large-scale studies such as the WHO-AIMS Report, community psychiatric surveys should be vastly implemented, as they are said to be "an essential part of psychiatric epidemiology" (Okasha, 2003, p. 46). Researchers go on to explain that these surveys "inform us about the need for services and whether these are changing; they allow us to examine disorders without the distortions of the referral process; they permit the identification of high-risk groups, and they enable us to examine the influence of important social and cultural factors" (Okasha,

2003, p. 46). There is great need for updated, extensive research on general population's consciousness, recognition, judgments and knowledge on mental illness and those living with disabilities.

The Age of Understanding and Acceptance

Morocco's population is inherently young, with 32.3% being under the age of 15, 41.9% being under 20 years old, and merely 8.0% remaining above 60 years of age (WHO-AIMS Report, 2006). This could be promising, as there has been a growing interest in conducting research on the help-seeking attitudes of students who have acquired a college education within Arab communities in recent years (Al-Krenawi, et al., 2009). Further studies are necessary in order to decide whether or not there is a correlation of education levels, stages of acculturation, younger generation Moroccans, and the expansion of more moderate and understanding views of those suffering from mental illness. If this hypothesis is correct, students of this caliber can serve as the "bridge between local traditions and modernizing forces, as they are receiving a post-secondary education, and are exposed to ideas outside their local cultures. These students may be a very useful conduit for understanding the intersection between the local and the global" (Al-Krenawi, et al., 2009, p. 34).

Traditional Considerations

Moving forward, it is essential to construct a system of training mental health practitioners to be sensitive toward, attentive to, and incorporative of traditional values into psychiatric practices to avoid refusal and skepticism of patients to modern mental health treatments. Therefore, the integration of *fquihs* could play a part in the patient's mental care, ensuring that they take their medicine regularly or leading them in reciting Koranic verses, creating a concurrent religious and psychiatric method of healing (Stein, 2000). Further research seeks to find a middle ground

between Western and traditional methods and ideologies in order to effectively and successfully treat those suffering with mental illness.

Proposed Methodology

If given access to an adequate sample size of participants, I intend on using a combination of Quantitative Methodology, such as via surveys scored on a Likert Scale, and Qualitative Methodology, such as interviews. Surveys would distinguish and categorize general subsections of the components and influences on mental health perceptions and the restrictions of treatments in Moroccan culture, as detailed throughout this academic article, whereas rich data such as reasons, or explanation of lived experiences, would result from further exploration on these categories through the interviews or ethnographic observations, serving as the Qualitative Methodology. The survey and interview questions would be drafted so that everyone is asked the same questions. Additionally, the survey questions would guide the nature of the interviews. As far as analysis on the data, I intend to look for themes in the Qualitative data and conduct a very simple statistical analysis for the Quantitative data.

Conclusion

Traditional, cultural, social, financial, legislative and religious aspects come into play simultaneously in hindering the betterment of the current mental health system in place in Morocco. Each of these components must to be taken into consideration and responded to accordingly in order for adequate development in both the Moroccan mental health sectors and the general population. In tandem with the legislative involvement and disbursement of funds for more resources, promoting awareness will be a leading factor in decreasing social stigmas that lead to insufficient or improper treatment. A balance must be sought out between traditional explanatory models and medicinal utilization patterns.

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